**Request for Children at Home Funds**

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| Child’s Name: | Child’s Date of Birth: |
| Description of Item/Service Requested: ***One*** item/service per form  **\*Proof of payment will be required for all reimbursements.**  **\* Please include order information, size, color, or other needed information** **to place order** | |
| Total Cost of Item: | Amount of Children at Home Funds Requested: |
| Who is to be Reimbursed: Family or Name of Provider and Mailing Address | |
| How would you like to receive funds:  EFT- Electronic Fund Transfer ( for this option please include a voided check)  Check mailed to address on file for reimbursements or Service Provider Invoice  Children at Home to Purchase item ( item would be shipped to address on file) | |

**Professional Statement:** Please complete the statement below.

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print name), care for the above named child and I am aware he/she demonstrates/displays the following behaviors or symptoms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ due to his/her diagnoses of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Providing child with the following item/service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will benefit him/her by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| Provider Signature: Title or License Number : Date: |

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| I declare that this information is true to the best of my knowledge. My family resides in the state of Iowa. My child has a disability and it is my intent to have my child remain living in my home. Services and supports purchased with these funds will not be used to replace other services or supports available to my family, including Medicaid and the Family Investment Program (FIP). |
| Parent Signature Date |